

Report on Provider Focus Groups



Developed by:
National Resource Center for Child Protective Services

GENERAL OVERVIEW

Focus groups with providers of safety and permanency services were held in Des Moines, Council Bluffs and Iowa City. Thirty two providers participated in the focus groups with the following breakdown among sites: nine participants in Des Moines, twelve participants in Council Bluffs and eleven participants in Iowa City. The purpose of the focus groups was to identify participants' observations and opinions about how the assessment and management of child safety and risk of maltreatment can be improved.

Participants were highly engaged in the focus group process and generally seemed enthusiastic about the opportunity to share their opinions. All appearances indicated that participants were forthright, open and honest about their opinions, beliefs, perceptions and observations about all aspects of safety intervention and the management of it. It should be noted that the results of a focus group should not be thought of as fact or evidence but opinion, perception and observation. Focus group findings represent more how participants think and feel about safety intervention and management. A copy of the power point with the questions that guided the discussion during the focus group meetings is attached.

FOCUS GROUP FINDINGS

Findings are reported in aggregate form for each question followed by summaries for individual focus groups. The objective of the report is to identify common themes, points of view, and perceived strengths and needs of the current system.

ROLE IN RISK AND SAFETY ASSESSMENT

GENERAL THEMES:

The focus groups included both front line and supervisory/management staff of contract agencies. Without exception they view their role in risk and safety assessment as significant and important. They see it as an ongoing process rather than a point-in-time assessment. Several agencies have some sort of assessment tool that assists with this responsibility. The North Carolina Family Assessment Scales was a tool frequently mentioned. Participants expressed the belief that they are in the best position to conduct risk and safety assessments because they are in the home on a frequent and regular basis and often are able to develop a level of trust with families so they are more likely to open up to them about what is going on.

DES MOINES FOCUS GROUP:

Participants identified assessment of safety and risk as central to their role as providers of both safety and permanency services. They conduct safety and risk assessments every time they are in the home, whether in a foster or biological home. They attempt to remediate the safety and risk issues through their work with families. Supervisors reported that they discuss safety and risk issues with their staff and how to address them.

Participants expressed the view that open communication is critical. They view their role with DHS as being part of a collaborative team. Communication is essential, especially as it relates to the safety of children. They make sure they are consistently reporting back to DHS about what they are observing in their work with families. Contact with the DHS worker is required every 30 days but it typically is more frequent than that.

COUNCIL BLUFFS FOCUS GROUP:

Participants described their role in safety and risk assessment as significant. Some participants said their agency uses a safety checklist to guide their staff in conducting safety assessments. All agencies represented in the focus groups use an assessment tool; the North Carolina Family Assessment Scales was the tool most frequently mentioned. Participants reported that they are constantly assessing safety, not just during the initial visit. They work hard not to get sidetracked with other issues so they do not lose track of the safety concerns. One participant expressed the opinion that assessing risk is as important as assessing safety and that they try to be proactive and address risk issues before they rise to the level of safety threats.

Supervisors said their role is to make sure that their staff is prepared and know what to look for in assessing safety and risk. They are in close consultation with staff to oversee and support them in their work with families. Supervisors also reported that they negotiate with DHS about expectations on individual cases. They see negotiation with DHS as a way to support their staff so they can concentrate on their work with families.

IOWA CITY FOCUS GROUP:

Participants who are frontline workers with families reported that they assess safety every time they are in the home. In addition to checklists for safety assessments, participants reported using the North Carolina Family Assessment Scales and the Family Functioning Assessment tool.

Participants who are supervisors described working behind the scenes to assist workers in conducting safety and risk assessments. They reported that they provide clinical supervision during regular meetings with individual staff in addition to weekly team meetings.

CONCEPTS OF SAFETY AND RISK

GENERAL THEMES:

Focus group participants were asked to describe their understanding of the difference between safety and risk. Immediacy of a concern was a criterion frequently mentioned by participants as a way to distinguish between safety and risk. The type of safety threat most frequently described by participants was present danger where the threat is imminent and immediate action must be taken to protect the child. Several participants expressed the opinion that there is confusion among DHS staff about the difference between risk and safety and that the safety threats are not always clearly identified when families are referred for safety services. There are occasions when the provider and DHS staff disagree on what is safety and risk; when disagreements occur they try to resolve them at the supervisory level if possible. There is a protocol in place for resolving disagreements on cases. Several participants mentioned the safety constructs developed by DHS as being very helpful in understanding the difference between safety and risk.

Focus group participants were asked to describe the training they have received that prepares them to assess safety and risk. All participants mentioned training that was provided by DHS in the fall of 2007 that forms the basis of their understanding of safety and risk. Periodic joint trainings on safety and risk were mentioned as something that would be helpful. Participants from one agency said that DHS is providing ongoing collaborative training and they have found it to be very helpful to ensure everyone is on the same page and has the same conceptualization of safety and risk. Participants from other agencies agreed similar training would be very helpful in their areas.

In addition to the training provided by DHS, all of the agencies represented in the focus groups described both pre-service and in-service training that is provided to their staff to assist them in their responsibilities with risk and safety assessment. Participants from only one agency expressed the opinion that their pre-service training does not adequately prepare staff for their safety management responsibilities. In order to compensate, supervisors in that agency supplement the pre-service training with additional training during supervisory conferences and team meetings.

In addition to pre-service and in-service training, participants described case consultation that occurs during supervisory conferences and team meetings. These meetings are used as opportunities to enhance their staff's knowledge of safety and risk and how to manage their responsibilities in those areas. The level of supervision provided to front line staff providing safety and permanency services as described by participants appears to be very high. In addition to regular supervisory conferences and team meetings, supervisors have frequent contact with workers by phone and impromptu discussions as needed.

DES MOINES FOCUS GROUP:

Participants reported that their definitions for safety and risk came from DHS; they were cross trained with DHS staff. Safety was described as an imminent risk of harm; someone will be hurt today or in the next hour. It is happening now. Risk was described as the potential for maltreatment but it is not imminent. Risk is viewed as more of an ongoing concern. An example given was a mother with a substance abuse issue. There would be risk of maltreatment but no immediate safety threat unless the mother is intoxicated and the child is present. Participants reported that DHS and providers disagree at times on what safety and risk are and that the definitions used by DHS staff can vary from county to county.

Some participants reported that goals in treatment plans tend to be written in very broad terms, e.g. parents will get an evaluation scheduled and completed, parents will get housing. Other participants reported that goals are too prescriptive, e.g. the provider will make sure there is food in the home, etc. Sometimes services start without a treatment plan in place but the family has already been referred for services. It is difficult to know where to start with the family in that situation unless a family team meeting is held at the time of referral.

One participant who provides safety services said their role is to monitor the safety plan while the CPS worker finishes the CPS assessment. Safety plans cover a 15 day period. Providers look at the safety plan on a daily basis and make changes if it is determined to be inadequate. Sometimes safety plans are too broad and providers rewrite them in more specific language. Some participants reported that, if a report is determined to be unfounded, DHS sometimes refers the family for another 15 days of safety services so the provider can continue to monitor the situation. Participants expressed the opinion that it would be more appropriate to make a referral for community care in those situations because there is risk in the family but it does not rise to the level of safety.

COUNCIL BLUFFS FOCUS GROUP:

Participants described safety as being an immediate threat; you cannot leave before taking action to ensure the child's safety. They described risk as situations where there could have been safety issues in the past; something could happen but it is not an immediate threat. Participants reported that they consider age of the child, parental capacity, support systems, financial status, and mental health and/or substance abuse issues when assessing safety. The attitude of the parents and how they feel about the child and their parenting responsibilities were also identified as important factors to consider when assessing safety. Participants expressed the opinion that there is risk in every family but some parents do not have protective capacities that are strong enough to balance the risk factors.

Supervisors expressed a high degree of confidence in their staff's ability to identify when risk factors rise to the level of safety threats. Some providers provide training on safety assessment to ensure that staff has the knowledge and skills to assessment safety and risk.

IOWA CITY FOCUS GROUP:

Participants defined safety as a child being in immediate danger. They reported that there is still a lot of confusion among DHS staff about the difference between safety and risk. They expressed the opinion that joint trainings would be helpful. Sometimes when DHS refers a case for safety services, they are not able to say specifically what the safety concerns are. Providers are expected to monitor the situation without knowing what specific safety concerns the DHS worker has about the family. One participant expressed the opinion that DHS workers define safety as whatever they want supervised visits for. Another participant said that DHS workers use safety services when they cannot put permanency services in because they have not completed the CPS assessment.

Participants described situations where there were disagreements with DHS staff over when to close a case. Concern was expressed by some participants that DHS wants them to stay involved even when the safety issues have been eliminated; there may be risk of future maltreatment but no current safety issues. One participant suggested that providers need to word their recommendations in stronger terms in the hope that they will carry more weight with DHS. Disagreements can work both ways. Sometimes DHS wants to keep a case open beyond the time the provider thinks it is necessary. In other situations the provider recommends that the case remain open and DHS closes it anyway. An example was given of a family whose case was closed four times and the family came back each time. The last time the case had not even been closed for one day before another report was received on the family. The participant expressed the opinion that there are safety issues in the family and that the case needs to remain open.

Participants talked about steps that have been taken to resolve differences on individual cases and to improve relationships between their agencies and DHS. One provider reported that supervisors from their agency meet with DHS supervisors every Monday and the results have been positive. Case closure is one of the issues that are discussed. Another provider said that they are holding joint trainings with DHS on a quarterly basis. During these trainings they discuss cases and talk about safety and risk. One benefit of the trainings is that they have helped to break down some of the walls and reduce the attitude among DHS workers that "I'm in charge and you're the hired help."

Participants discussed what they perceive as a blurring of the distinction between safety and permanency services. At times they believe families are referred for permanency services but the actual services the agency is asked to provide are safety services. Participants described safety services as crisis intervention; being the eyes and the ears to ensure children are safe. They described permanency services as ongoing skill development. Participants expressed the opinion that they, as providers, should determine how often they need to be in the home.

One agency reported that DHS workers have used them to go through closets, look under the bed and in the garage and to go out at night. The agency believed DHS was putting them at risk regarding the own safety and suggested that they should have the police go at night.

SHARING OF INFORMATION

GENERAL THEMES:

- Information sharing has improved but still varies from office to office and worker to worker within offices.
- Providers typically receive a copy of the assessment at the time of referral but do not routinely receive other documents that would be helpful to them in their work with families.
- It works best if a family team meeting is held at the time of referral so the DHS worker, family and provider have an opportunity to discuss reason for agency involvement and next steps.

DES MOINES FOCUS GROUP:

Participants agreed that information sharing has improved but they still see variation from office to office and worker to worker within offices. Participants reported that, at the time of referral, they typically receive the CPS assessment and safety plan but not the safety assessment or case plan. It is most helpful to have the DHS worker there for the initial visit with the family.

COUNCIL BLUFFS FOCUS GROUP:

Participants reported wide variation in the information they receive from DHS at the time of referral. Concerns expressed included:

- Safety plans are not always received on safety cases. One provider estimated that they receive a safety plan in 1 in 25 cases.
- When a copy of the assessment is not provided, the agency does not know what is going on with the family until they go out and conduct their own safety and risk assessment.
- For permanency services, Form 3055 is often the only document they receive. It would be helpful to have other information to prepare them to work with a family.

Participants expressed the opinion that DHS workers should be required to share the following information with providers:

- CPS assessment;
- Court orders;
- Safety plans;
- Contact information;
- Phone call with the referral;

Participants were asked the percentage of cases where they get adequate information. Responses ranged from 75%-95%.

IOWA CITY FOCUS GROUP:

Participants reported that they do not always get sufficient information to know what is expected when a family is referred for safety or permanency services. A referral form is typically received but other important documents, e.g. CPS assessment, case plan, etc. are not routinely received. One agency has instituted a requirement that DHS call to make a referral rather than sending a referral form. This agency fills the referral form out over the phone. The form has safety and protective capacity questions. DHS sends over the face sheet and Form 3055. This arrangement has worked well.

Participants expressed the opinion that DHS workers should be required to share the following information with providers:

- Safety concerns;
- Child vulnerability;
- Parent protective capacities;
- Authorization form;
- Case plan;
- Court documents;
- Child abuse assessment;
- Placement history if child is in foster care and what needs to happen in order for child to go home;
- Parents contact information;
- Additional addresses & support system contact information;

Participants were asked how frequently they receive adequate information on cases that are referred for safety or permanency services. The responses ranged from 75-100% of cases. One agency reported that they only receive adequate information on 10% of permanency cases. Another agency reported that family team meetings are always held in their area but they do not always receive adequate notice.

WAYS DHS COULD ASSIST PROVIDERS

GENERAL THEMES:

- Behaviorally specific outcomes;
- Trust providers' recommendations, especially regarding visitation;
- Make sure that DHS staff know the details of the contracts with providers so they have realistic expectations;
- Have regular meetings that include DHS staff (line workers and Service Area Administrators) and staff from contract agencies to build team work and sense of collaboration.

DES MOINES FOCUS GROUP:

Many of the suggestions generated in response to this question related to the terms of the contract and what are perceived as unrealistic expectations, especially regarding supervised visits. The number of visits per week increased when the contract went to a flat rate. Two

visits per week used to be the average but now it is not unusual for four or five visits to be required per week. Providing transportation and supervising visits takes up what participants believe to be an inordinate amount of time each week and can involve long travel distances, putting a financial strain on agencies since they are not paid for mileage.

Improved communication and collaboration on cases were also identified as ways that DHS could help providers in their work with families. Participants expressed the opinion that DHS and providers should be working as a team to do what is best for the family but they do not always feel that DHS workers respect their professional opinion. An example that was given was cases where safety concerns have been resolved but the worker keeps finding reasons to keep the case open that are not safety related. Participants also reported that they do not get the information they need in a timely manner and, once they get it, it isn't updated. Another recommendation related to communication was to use consistent language to describe safety.

Participants acknowledged that there are many players, e.g. attorneys, DHS, providers, court, etc. who are involved in decision making. Sometimes decisions are made that DHS does not have control over. An example given was a mother who has overnight visits but the children are not returned because the mother pierced her nipple. This decision was made by the attorney.

COUNCIL BLUFFS FOCUS GROUP:

Improved communication on cases, including monthly joint visits with families, was one of the recommendations made in response to the question of how DHS could help providers in their work with families. Another recommendation was for behaviorally specific outcomes. The opinion was expressed that outcomes are too general and that 90% of cases have the same outcome. Workers copy and paste general outcomes rather than writing outcomes that address the specific needs of individual families. It makes it difficult for providers to know where to start with families.

Participants expressed concerns about their role in supervising visits. One participant described visitations as “frustrating” and said that their agency is spending so much time doing visits there is not time to work with families. Another participant offered the opinion that some DHS workers use supervised visits as punishment for parents. The worker might cut back on the number of visits or make visits supervised even if it is not necessary from a safety standpoint. An example given was when the parent relapses in a case involving substance abuse issues.

Another concern expressed by participants was whether or not line DHS workers know the details of the contracts with providers. There is a general perception that supervisors and administrators know the specifics of the contracts but line workers do not. The lack of understanding by line workers leads them to have unrealistic expectations of providers.

Although participants believe relationships have improved, there is still a need to build trust on both sides. Agencies want to help families but do not trust that they will be backed and that DHS trusts that providers know what they are doing.

IOWA CITY FOCUS GROUP:

Improved communication and relationship building were recommendations made by participants in Iowa City. Participants would like to see their relationship with DHS to be a partnership and for them to work together as a team. They expressed the opinion that it used to be a more even playing field but now they are back to DHS workers thinking providers work for them. Improved communication, including regular meetings where roles are discussed, were offered as ways to improve relationships. Generally, relationships at the supervisory level are better than with workers. In spite of the current challenges, participants believe DHS wants to make it work and that it is going to be a successful partnership.

Participants also expressed concern about their responsibilities related to transportation. One participant expressed the opinion that they are being used as a cab service. Transporting children for visits with parents takes a lot of providers' time. Participants expressed the opinion that it would be helpful if DHS could trust providers to know if visits need to be supervised.

ASSESSING CHILD SAFETY

GENERAL THEMES:

Participants were able to identify some of the key factors to consider when assessing child safety. All of the participants acknowledged their responsibility for managing safety but were concerned about whether they always have sufficient information to carry out their responsibilities effectively. Additional training would be helpful to ensure that providers are using the same definitions and are considering the same factors in their assessment as DHS staff are using. From the comments made in all three focus groups, it appears that providers are focusing on present danger and may not have a full understanding of impending danger and how to assess it. Training on the concepts of present and impending danger, therefore, is recommended.

DES MOINES FOCUS GROUP:

General consensus among participants is that there is a need for additional training regarding safety in order to achieve consistency in terminology and the factors considered when doing a safety assessment. Participants expressed confidence in the three safety constructs DHS is using and believe the constructs provide a framework for safety management but that additional training is needed in order for providers to be proficient in the 15 areas on the safety tool. Some participants expressed the opinion that the focus tends to be on immediate safety threats rather than risk or safety threats that are less obvious. This is another area where participants believe additional training is needed and expectations made clear.

COUNCIL BLUFFS FOCUS GROUP:

Participants discussed the factors they consider when assessing child safety. The motivation of parents to keep their child safe and their cognitive ability were two factors identified. Other factors participants consider include:

- Age of the child;
- Other people coming in and out of the home;

- Whether they acknowledge risk or not;
- Visibility to the community.

Supports through community services, e.g. day care or relatives coming into the home can mitigate some of the risk factors.

IOWA CITY FOCUS GROUP:

The following list of factors was generated by participants during a discussion about what factors they consider in assessing child safety:

- Behaviors by the parent that are placing a child at risk;
- Accessibility of children. Are the children visible to them or is the child always sleeping when they visit?
- Interaction between child and parents;
- Availability of informal supports for the family;
- Who is involved with the family, do they know the warning signs, and are they reliable;
- Physical hazards in the home;
- Mental stability of the parents;
- Parent's attitude about and toward their child – are they protective or always negative towards their child?
- Frustration level of the parent;
- Whether parent has age appropriate expectations of child.

HOW INFORMATION ABOUT SAFETY AND RISK IS USED

GENERAL THEMES:

Participants from all three focus groups reported that they use information about safety and risk to prioritize the issues they address with families. Each agency has an assessment tool that is used to identify the areas that are most critical to address. It would be helpful to get more information from DHS that could be used to inform their work with families, especially in the early weeks and months when they are getting to know the family. Increased communication between providers and DHS staff, in addition to increased sharing of information, was identified as a something that could help providers focus their work with families.

DES MOINES FOCUS GROUP:

Participants reported that they focus their work with families on the safety and risk issues. They consider what brought the family to the attention of DHS but also use the information from their own assessment of the family. Many times they find there is more going on with the family than was learned during the protective assessment conducted by DHS. They try to keep their work focused on the issues that are impacting the parents' ability to keep their children safe. Participants described challenges they encounter in staying focused on safety due to pressure from DHS staff to address other issues. One participant said that the expectation is that the "providers will do everything and make the family into the Cleavers."

Participants expressed concerns about the terms of the current contract. Providers are paid a flat rate that decreases at ten months and again at fifteen months. The service needs of the family do not always decrease, however, so providers are providing a higher level of service in some cases than they are getting compensated for. Another concern expressed by participants is that DHS staff does not always listen when they tell them it is safe for a child to return home so they are “stuck” working with families that no longer need their services.

COUNCIL BLUFFS FOCUS GROUP:

The consensus of participants is that the safety and risk assessments help them to prioritize where to begin with families. Information about safety and risk also helps them decide how prescriptive to be and how strong a stance to take with families. An example given was that if there are major safety issues in a family, you have to be really firm about setting limits and outlining the consequences that occur. It also helps to know when outside supports are needed and whether someone needs to watch the family and to call with concerns. Participants also reported that information on safety and risk helps them create a timeline with a family to complete tasks.

When asked whether they negotiate with families about what issues are going to be addressed, participants said that there are some non-negotiable issues and that safety is one of them. They try to explain the federal timelines to parents and use those to help the parents to look ahead and to feel some urgency about pushing forward. One agency has a booklet about the court process that is shared with families to help them understand the court system. Participants said that the majority of their cases are court is court involved; the range was 50% to 99%.

In response to a question about how successful they are in engaging families, participants reported a high degree of success. Some of the strategies used to engage families include letting them know that they are not taking off and that they are there to help them get done what needs to get done so they are no longer involved with CPS. It is also helpful if they can provide some immediate assistance to reinforce the idea that they are there to help and support the family. If the parents are not responsive, they try to engage other family members.

Participants were asked whether family engagement is addressed in training or through ongoing supervision. Responses from participants were mixed. Some reported that the initial training includes family engagement and rapport building techniques. Others said that it is covered in staffing or in supervision on a case-by-case basis.

IOWA CITY FOCUS GROUP:

Participants reported that the assessment tools their agencies use are very helpful in identifying what areas to focus on in their work with families. An agency that uses the North Carolina Family Assessment Scales uses the scores to prioritize the issues to be addressed. Participants said that the family team meetings are critical in identifying the issues to be addressed and to

establish timelines and what the provider is supposed to do. Participants reported that they have found that staffing cases in small teams is very useful to brainstorm strategies and to generate insights from a different perspective.

A question about how outcomes in the case plan are used in deciding what approach to use with families drew a varied response from participants. Some said that the case plan is useful if it is not too dated. Many participants said that they do not always get a case plan and, if they do, it is three months or longer into the case. Participants also reported that they seldom get court orders, even when they are court ordered to do things. They sometimes are able to get a copy of the order from the Guardian-ad-Litem. One participant expressed the opinion that DHS workers do not want them to have court orders so they can get them to do things that are not court ordered.

Participants expressed the need for accountability on both sides. At this point, they feel they are being held accountable but there DHS is not. Increased communication through regular meetings was identified as a way to improve relationships and to work together more effectively.

HOW TO ASSESS WHETHER STRATEGIES ARE WORKING

GENERAL THEMES:

Assessment tools and family team meetings were the methods participants in all three focus groups reported using most frequently to assess progress in cases. Having behaviorally stated goals is helpful so the family knows what is expected and it is easier to measure progress or the lack thereof. It is important for families to have some quick successes early on in the case to motivate them and to build their confidence.

DES MOINES FOCUS GROUP:

The incidence of recurrent maltreatment was one way participants said they assess whether strategies they are using with a family are working. They also reported that they rely on the assessment tools their agencies employ. They recognize the need to continually assess the family throughout the life of the case. Family team meetings are also helpful in assessing progress by hearing what the family and others think is going well and whether changes are needed in the service plan.

Participants discussed the difficulty they encounter in some cases in deciding when their work is through. The providers and DHS do not always agree on whether sufficient progress has been made or when a case can be closed. Participants discussed the need for flexibility in addressing the goals that are established in a case and the importance of not imposing their standards and biases on families. Child safety is what is most important. They need to keep their eye on the safety issues and not all the other “stuff” that is not impacting safety.

COUNCIL BLUFFS FOCUS GROUP:

Monthly reports were identified as key to assessing progress in cases. Supervisors read the monthly reports and talk about them in meetings with workers. Participants from one agency said they start with outcomes, e.g. parenting skills, and break it down into things that can be done right away. Momentum is very important. It is best to start small so families can see some success.

Participants discussed the difficulty in assessing progress when there are not clear outcomes identified in cases. Some case plans have very broad outcomes, e.g. parents will remain drug free and others have long lists of what the provider must do.

Family team meetings were identified as key to ensuring everyone is on the same page and to ensure that the family's goals are included in case plans. Participants expressed the opinion that when family team meetings are held early on in the case, families make progress more quickly. One agency expressed the opinion that family team meetings are not held frequently enough, especially in outlying communities. With busy schedules, it can be difficult to get the various players in a case to take the time to have a meeting.

IOWA CITY FOCUS GROUP:

Assessment tools and 30 day reports were also identified as key to assessing progress by participants in the Iowa City focus group. They also use team meetings to discuss goals that were set, what has been met and what has been done to help families meet those goals. Other measures that are used to assess progress include:

- Case closure;
- Input from other professionals on how family is doing;
- How often they have to be in the home;
- Is the family demonstrating what they are being taught?
- Consistency, not only in what you see on scheduled visits but on drop-in visits;
- Clean drug tests.

COMMUNICATION BETWEEN PROVIDERS AND DHS

GENERAL THEMES:

Although participants in all three focus groups expressed concerns with communication between their agencies and DHS, they believe it is getting better. Some variation is seen from worker to worker and most participants reported more success with e-mail than phone calls. Communication with DHS supervisors tends to be better than with line workers. Concerns were also expressed about the terms of the contracts between DHS and providers and a lack of understanding on the part of some DHS workers about the terms leading to unrealistic expectations. The general perception of participants in all three focus groups is that DHS is trying to be responsive to their concerns.

Suggestions for ways to improve communication include:

- DHS workers sending information about the family at the time of referral;
- Monthly staffing between the DHS worker and care coordinator.

DES MOINES FOCUS GROUP:

Participants identified several concerns about the level and quality of communication with DHS workers. Communication varies from worker to worker. Some workers are very responsive and respectful in their interaction with providers. Other workers consistently do not return phone calls and interact with providers in ways that they interpret to be disrespectful. Some participants said they have more luck getting responses from DHS workers via e-mail than voicemail.

Participants talked about the requirement in the new contract that providers use a model that is evidence-based. Many providers are using solution-focused models and motivational interviewing. They are at various stages of implementing their models and voiced the opinion that implementation has been hampered by the DHS workers wanting to decide what needs to be done rather than trusting that providers know what the family needs. Participants expressed concern about compliance-based outcomes in the contract rather than progress made by families. An example given was a provider being held to a program improvement plan because they did not meet a 24 hour deadline to send an e-mail, even though there were extenuating circumstances, e.g. weather and no electricity. However, this provider has closed more cases than other providers and has a lower rate of recurrence.

Participants reported their agencies are losing money doing safety services. They cannot control life situations such as people not being home or the weather and these things affect the payments they receive. Even if the level of effort was there, they are not always compensated accordingly. Participants expressed the opinion that they are not always evaluated or compensated based on keeping children safe.

When asked how they handle time management, participants said they worry about burnout and turnover. The turnover rate is higher since the new contracts were implemented. Under the old system, DHS would find someone to help with seeing clients in another part of the state. Now it is the responsibility of the provider and they cannot afford to do it with mileage and time involved. Participants also expressed concern that all DHS workers are not educated about the contracts so they have unrealistic expectations. They expressed the opinion that they are spending more time trying to keep track of paperwork for the DHS and it is taking time away from working with families.

Although there are problems with the new contracts, participants said that DHS has done two rounds of amendments that have been helpful and are planning another round of amendments in October. They believe that DHS is listening and trying to be responsive to their concerns. The challenge is how to measure performance without getting caught up in the minute details. The

providers have not seen any output from the Department from the e-mails, reports and other compliance-based measures they require.

COUNCIL BLUFFS FOCUS GROUP:

Participants reported that communication with supervisors is better than with line workers. On a scale of 1-10, participants rated communication with supervisors as a 9 or 10. Ratings for communication with line workers ranged from 3 to 7 with most ratings at 5 or 6. The most frequently voiced concern with communication was difficulty in reaching workers and not having phone calls returned in a timely manner. Participants also voiced concern about workers not understanding the terms of the contract. Examples given were the minimum contact requirements for the contract and who has the authority to remove children from the home. Providers have had workers ask them to remove children from the home. There is a perception that some workers see providers as beneath them and that they can tell providers what to do. The quality of relationship between workers and providers varies from worker to worker. Increased in-person contact through meetings and trainings is viewed as a way to improve communication and understanding as well as to build trust.

Other recommendations for ways to improve communication include:

- Sending information at the time cases are referred;
- Monthly staffing between the DHS worker and care coordinator;
- Have providers complete surveys on workers similar to the surveys workers complete on providers;
- Have workers carry cell phones so providers so they are more accessible to providers;
- Share contact information upfront to help providers locate families.

IOWA CITY FOCUS GROUP:

Participants reported that communication with DHS staff is generally good. The quality tends to be higher with supervisors and upper level management but ratings for all were in the 7 – 10 range. Only two agencies rated communication in the 4 – 6 range. Those agencies reported that the quality of communication varies from worker to worker. All of the participants voiced the opinion that communication with DHS is getting better; they talk regularly and give feedback to each other.

WAYS TO WORK TOGETHER MORE EFFECTIVELY

GENERAL THEMES:

Communication on an individual case basis as well as group meetings and trainings was the most frequently recommended recommendation in all three focus groups. Increased communication, preferably face-to-face, is essential to promoting team work and a sense of trust between DHS staff and providers. Addressing ongoing concerns with the current contract also emerged as a priority in all three focus groups. The time and expense involved with transporting children for visits and supervising visits was the most frequently voiced concern with the contract. In spite of the concerns, all of the providers that participated in the focus

group expressed the opinion that DHS is headed in the right direction and that their relationship with DHS has improved and they are optimistic that it will continue to improve.

DES MOINES FOCUS GROUP;

Many of the responses to this question related to providers' contracts with DHS. Participants voiced the opinion that expectations increased when they went to a lump sum payment rather than a fee for service arrangement. They sometimes have to transfer cases between staff which is not good for families or service providers. It is economically driven because they cannot afford to have their more tenured staff providing services for which the reimbursement rate is low. Also, with family visits frequently occurring on weekends, their staff has to work weekends on a regular basis. Long travel distances are frequently resulting in even more of an economic impact on providers since they are not paid for mileage and the reimbursement rate is not higher for weekend work. The reduced payment at 10 and 15 months was also identified as a challenge for providers. There are experiencing increased burnout among staff and higher rate of turnover due to the stress and working conditions, e.g. travel, evening and weekend work, etc.

Although participants expressed concerns about the current contracts, they also said that some of the changes have been positive. An example given was that they have more leeway in what they are doing with clients; they can write in reports what they did and who they met with rather than being limited to prescribed language.

Improved communication and relationship building were also frequently mentioned as ways that providers and DHS could work together more effectively. One participant offered the suggestion that they should practice what they preach, e.g. having better communication and not being judgmental, listening to each other, having trust, and respecting each other. Another participant suggested that frequent and regular face-to-face meetings involving the worker, provider, and family would be helpful. Keeping the focus on what brought the family into the system was another suggestion generated by participants. Regular meetings by service area and mandatory attendance by Service Area Administrators are viewed as a way to promote a more collaborative relationship between providers and DHS staff. Participants expressed the opinion that the involvement of Service Area Administrators is critical to improving relationships between DHS staff and providers.

COUNCIL BLUFFS FOCUS GROUP:

Communication, collaboration and team work were themes from the discussion about how providers and DHS staff could work together more effectively. Joint visits with the family on a monthly basis would improve communication on individual cases. Regular meetings and trainings on a service area basis would help develop a sense of team work and a spirit of collaboration. Giving DHS staff the message that providers are part of a team and not there to work under the DHS worker was another suggestion.

Several participants expressed concerns related to foster parents and what they perceive as too much power being given to them. Concerns included foster parents being able to determine when visits occur and being given the option of refusing to provide transportation for visits, mental health appointments, etc. Participants expressed the opinion that some foster parents sabotage reunification efforts because they want to keep the children or do not think that reunification is appropriate. Other participants expressed concern about what they perceive is a lack of support for foster parents for what is a tough and emotionally draining job. Some foster parents do not know what support is available for them. They might be told during the initial training but need a refresher or reminder later on. Consensus of participants was that the initial training for foster parents is excellent.

IOWA CITY FOCUS GROUP:

Increased communication and team work were themes that were generated during the discussion. Monthly meetings to discuss cases and systems issues were recommended to improve communication and to develop a sense of team work. Both sides have to realize that they will not always agree but should be flexible with each other. The Service Area Administrators were identified as key players and essential to be part of meetings. Trust was also identified as important – trusting the provider to be the provider, letting go of the old way of doing things, trusting the provider to take care of the family, trusting the process.

Attachment - Focus Group Questions



Developed by:
National Resource Center for Child Protective Services

Iowa Department of Human Services

Provider Focus Group

Conducted By

The National Resource Center
for Child Protective Services

Introduction



- ❖ National Resource Center for Child Protective Services
- ❖ Facilitator and Participants
- ❖ Context: System Review
 - ♦ Policy and Procedures
 - ♦ Supervisory Training
 - ♦ Safety and Risk Management
 - ♦ Focus Groups
 - ♦ Communication



- ❖ Informal – Relaxed
- ❖ 2 Hours for Group Discussion
- ❖ National Resource Center Role
 - ♦ Facilitate Discussion
 - ♦ Focus Discussion
 - ♦ Record Observations

Purpose of Focus Group

- ❖ To identify participant observations and opinions about:
 - ◆ How the assessment and management of child safety and risk of maltreatment can be improved.

Focus Group Questions



Question #1

What role do you play in assessing child safety and risk of maltreatment?



Question #2

How would you describe the difference between safety and risk?



Question #3

What training have you received that prepares you to assess safety and risk?
What areas would be helpful to know more about?



Question #4

What information does DHS share with you that helps you assess and manage child safety? Is there information that you're not getting currently from DHS that would be helpful to have?



Question #5

Name one thing that DHS could do that would help you in your work with families.



Question #6

What have you found is most important to look for in assessing child safety?



Question #7

How do you use information about safety and risk in deciding what approach to use with a family?



Question #8

How do you assess whether the strategies you're using with a family are working?



Question #9

How would you assess the level and quality of communication with DHS?
How could it be improved?



Question #10

What is one way that your agency and DHS could work together more effectively to keep children safe and reduce the risk of maltreatment?

Thanks for
sharing your
thoughts and
opinions.